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Editorial: Teaching Social and Behavioural Sciences in Medical Education

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Abstract

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Article

Introduction

"A complete medical education must include, alongside the physical and biological science, the perspectives and findings that flow from the behavioral and social sciences" (Association of American Medical Colleges 2011)
Research worldwide consistently shows that social and behavioural factors influence illness across the entire medical spectrum. This recognition has prompted a number of key reports including the US (AAMC, 2011) and UK (Frenk et al. 2010) to call for reforms in medical education to properly equip graduates with the skills to identify societal and behavioural factors that contribute to illness or impede treatment. The challenge for medical educators has been to move from a traditional biomedical curriculum to one that also incorporates social and behavioural sciences (SBS), prompting a number of core questions:

What should be considered core SBS content for medical education?

It is widely acknowledged that SBS content is important to include in the medical curriculum. Key institutions in the U.S., (including the Institute of Medicine, National Institute of Heath, American Association of Medical Colleges) and the UK (General Medical Council, Behavioural and Social Science Teaching in Medicine, Public Health Educators in Medical Schools), have identified core SBS curricular content and learning outcomes (Institute of Medicine 2004; BeSST 2010, 2015) including the

following: social and cultural determinants of health, illness and disease; patient behaviour; the experience of illness; biological mediators of SBS factors and health; physician – patient interactions; physician role and behaviour; health policy and economics. This is a diverse and wide ranging list and it is not yet clear to what extent medical schools do include these topics as core; or more generally why and how decisions about SBS content are taken.

Where and when should SBS be included in the medical curriculum?

SBS should be integrated into the curriculum in a way that ensures adequate consideration is given to the relevance of SBS content throughout all stages of students' learning. Discussion with colleagues across many medical schools in the UK and internationally highlights that the models of integration of SBS being adopted are diverse, including: disciplinary specific (often concentrated in the early pre-clinical years), multidisciplinary (where SBS has allotted time within a course to address its particular take on the theme or topic being discussed) and interdisciplinary (where SBS is integrated as part of a holistic curriculum design in which disciplinary labels disappear). However, there is limited research to explore the implications of these models of curriculum integration for SBS learning outcomes.

Who should be involved in developing and delivering SBS in the medical curriculum?

Effective integration requires collaboration between clinical, basic science and SBS faculty, drawing on the expertise of all to ensure that SBS content design, delivery and assessment is appropriate, timely and relevant (Carr 1998). Yet we know that this is not always straightforward (Russell et al 2004) and there is evidence of challenges arising when the expectations and vision of clinicians, basic scientists and SBS specialists differ (Satterfield 2004). How can we work towards a more collaborative approach that draws on the strengths of SBS specialists, basic scientists and clinicians?

How can SBS be taught and assessed to enhance students' learning?

There is a wealth of discussion around innovative developments in teaching in medical education and it will be interesting to hear how new methods are applied in the context of teaching SBS subjects. For example, what activities work in large class flipped learning sessions for more discursive social science topics? JH (Harden and Carr Forthcoming) suggest 'top tips' that would be interesting to see fleshed out in some of the papers in this issue: encourage active learning; ensure learning opportunities provide added value; connect to the real world; be realistic about time; provide clear learning guidance. Similarly, discussion relating to assessment methods highlights the broader challenges faced by all; of balancing different requirements relating to validity, reliability, and feasibility. How are these issues addressed when designing SBS assessment; specifically, can we assess SBS outcomes using multiple choice questions? The level of integration reflected in the curriculum structures will also influence the modes of assessment. When delivery is integrated it is important to ensure that SBS content is included in assessment (Litva and Peters 2008).

How can the integration of SBS into the curriculum be supported?

Implementing an SBS curriculum requires the support of the medical school administration. Institutions

whose faculty and administration have both the vision and commitment are more likely to succeed in developing and implementing a comprehensive, integrated, curriculum. How can we enhance this vision and commitment in our own institutions and collectively across institutions?

Conclusion

We have posed a number of questions that we regard as key and hope that these questions resonate with those involved in teaching or developing curricula related to SBS in medical education. We would be very interested to hear your views and experiences in a range of formats including: research papers; systematic reviews; case studies; descriptions of new education methods or tools; practical tips and guidelines; personal views and opinion pieces. So please think about contributing and help us to move the discussion about SBS in medicine forward.

Take Home Messages

Notes On Contributors

Dr Jeni Harden is Director of Education in the Usher Institute of Population Health Sciences and Informatics, in the University of Edinburgh's Medical School and a Fellow of the Higher Education Academy (HEA). She is the joint theme lead for 'social science and public health' throughout the Edinburgh medical curriculum and is also responsible for the development of, and teaches on the Year 1 module Health, Ethics and Society.
Dr Kathleen Kendall is Associate Professor of Sociology as Applied to Medicine in the Faculty of Medicine at Southampton University. She is the subject lead for Sociology within the Faculty and also teaches on the Global Health and Ethics in a Complex World interfaculty modules. While at Southampton she has held various educational leadership roles including developing and implementing a new curriculum. She has received the Vice-Chancellor's Teaching Award three times. Her educational research has included work on diversity teaching and student well-being.
Dr Sara MacBride-Stewart is a Lecturer in the School of Social Sciences, teaching in the School of Social Sciences, and in the Cardiff Medical School. She has previously worked as a Research Fellow in CISHE (Cardiff Institute of Society Health and Illness) at Cardiff University School of Social Sciences, and at the University of Canterbury, New Zealand. Her research interests are broad, with current projects on gender and sustainable place-making, representations of dying well, equalities and sexualities, infertility and inequality and medical professionalism. She is a core member of BeSST (Behavioural and Social Sciences Teaching) in Medicine group, is an HEA affiliate, and she has in the past co-chaired the Wales BSA MedSoc group.

Acknowledgements

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Appendices

Declaration of Interest

The author has declared the conflicts of interest below.

Dr Jeni Harden, Dr Kathleen Kendall and Dr Sara MacBride-Stewart are Guest Theme Editors of AMEE MedEdPublish for the theme of Social and Behavioural Sciences in Medical Education.